VOL. 14, NO. 6 MARCH-APRIL, 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham. N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physical examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Medical Director

GEORGE H. ADAMS
Educational Director

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EMOTIONS GUIDE LIFE ACTIONS — USE THE RIGHT ONES

BY JAMES L. ALFORD, M.D.

EVERY living organism wants to survive. Most living organisms want to avoid pain. Every human being wants to survive, avoid pain, and seek pleasure; and for many the ultimate in pleasure is to be creative and to contribute something to the lives of others.

Lower forms of life do not have much choice—they either survive or they do not survive. Their means of adapting to their surroundings are very limited. The higher we go up the animal scale the more means we find for adaptation. Finally, we come to man, and theoretically, he has the greatest number of faculties to adapt, to survive, to avoid pain, and to obtain the greatest amount of pleasure from his surroundings—including other people. But, does he use these faculties? Not often, and not well. Over and above the lower animals he was given intellect which was to be his greatest power in the search for pleasure and avoidance of pain. Unfortunately, however, there are powers in man that are seemingly stronger than intellect, especially when they are at work. These often unknown, unrecognized powers stronger than intellect, are the emotions.

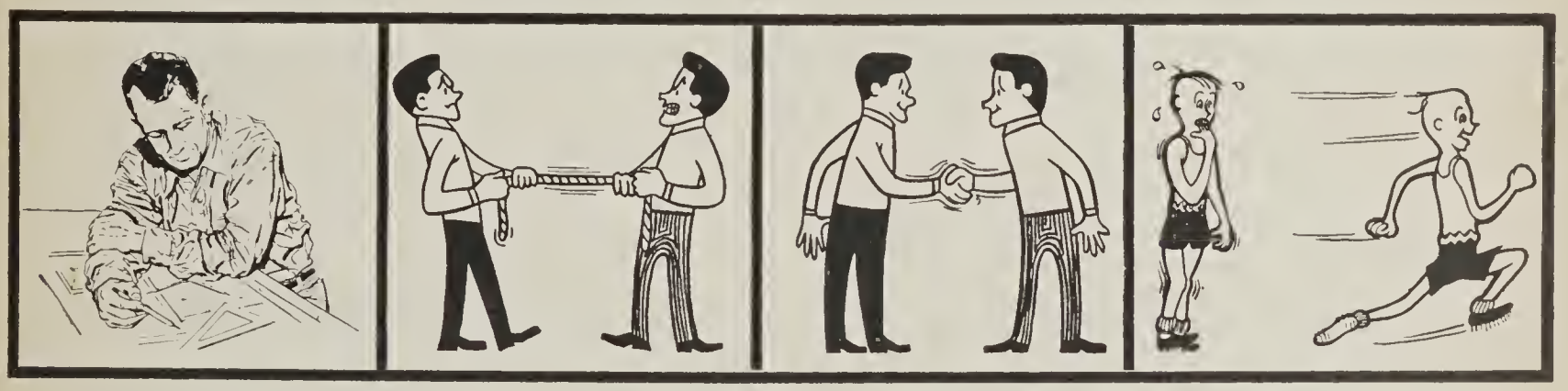
The emotions can be those that are meant to be reserved for emergencies (to avoid pain)—anger, fear and guilt—and those that are meant to be used for the ultimate in pleasure (creativeness)—love, acceptance, compassion, and sympathy.

Early in life man learns by his relationships with other people to use his emotions correctly or incorrectly; and, with the help of these emotions, he modifies his life patterns in order that he gets as much pleasure and as little pain from life as possible. Unfortunately, oftentimes, early in life, because of poor interpersonal relationships, an individual learns only to react through the use of his emergency emotions and he is either angry, frightened, or feels guilty. As a result of this early training and his continuing over the years to misinterpret situations, he carries the emergency emotions into situations where they don't belong. As a result, even though he is not aware of it, he frequently reacts with anger where anger is not needed, or with fear where trust could be, or with guilt where he was without guilt.

Let me illustrate this with an example. A boy is brought up in a home where the father is a chronically angry man who is constantly threatening, beating, yelling, condemning whoever gets in his way. The boy sees this behavior over and over again. He is alternately frightened and angry at his father, then feels guilty for being angry because one is supposed to love his father. But who can feel love for someone of whom he is constantly fearful? The boy grows up always frightened by men in authority. He doesn't like school teachers, coaches, policemen, bosses, preachers, doctors, or anyone who stirs up the emergency emotions of anger, fear or guilt. Emotions in him are constantly ready to fly to his defense to prevent him from being harmed, even when there is no real danger that he will be.

In the clinic the community atmosphere is one which is to promote the constant attempt on the part of each community member—staff and patients alike—to constantly ask himself, "What emotion am I feeling? Is it anger? Is it fear? Is it guilt? Is it love? Is it acceptance of the other person? Is it acceptance of myself?"

Oftentimes someone else can help a person identify what emotion he is experiencing better than he can



himself — hence, group meetings. Once the emotion is identified, then he must ask himself, "Is the emotion appropriate to the situation? Should I really feel angry in this situation? Is it all right to be frightened? Am I guilty of doing something I really believe is wrong?" And also, "How do other people feel in the same situation?"

Once a person has learned to recognize how he feels—how he really feels—in a given situation, he is a long way along in being able to do something about those emotions which he heretofore did not know were at work and were unknowingly guiding his life actions.

LATEST ON OVER-DRINKING

Leading Authority Answers the Questions Social Drinkers Ask

CONTINUED FROM THE JANUARY-FEBRUARY ISSUE

From a recognized authority on alcoholism comes a guide for social drinkers—how much it is safe for a person to drink, when and how often, the danger signs of over-drinking.

Any harm in a drink or two before dinner? How about cocktails at lunchtime? Should parents worry about teen-age beer parties?

In answering these and other questions, Dr. Marvin A. Block reports the latest medical findings on drinking, and gives his own views on how a man can enjoy alcohol without running the risk of becoming a problem drinker.

Dr. Block was interviewed by staff members of "U. S. News & World Report."

Reprinted from the June 15, 1964 issue of U. S. News & World Report, published at Washington.

IF CONTROL IS LOST—

Q What is the basic difference between an alcoholic and a so-called social drinker?

A I think the exact parting of the way between the alcoholic and the non-alcoholic drinker is loss of control.

The social drinker is the one who has control. He can stop when he wants to.

The alcoholic, once he starts to drink, has no control. He drinks until he is unconscious, or someone takes him in hand. Now, of course, there are many alcoholics who keep saying, "Well, I can stop any time I like." But they don't.

Q Why don't they? Is it lack of will power?

A They can give you any number of excuses—what they call "reasons"—why they don't. But the strange part is that they don't. And when they try, they are often astounded to find that they cannot go without drinking. Then they begin to get frightened. And when they get frightened, they drink to do away with the fright. And they are hooked again.

Q It's a vicious circle—

A Absolutely. One must bear in mind that the alcoholic does not drink for "fun," necessarily. He drinks to put himself in a different state of mind, and a more comfortable one for him.

As a rule, the alcoholic is a sick, unhappy, miserable individual who takes this drug because it is socially acceptable—unlike narcotics. He drinks it excessively only to put himself into a situation or condition which is more tolerable to him than his life without it.

Q What are the warning signs of alcoholism?

A Some of the questions regarding early signs that we see are:

Do you go on frequent drinking sprees? Do you drink the first thing in the morning? Do you miss time from your work or your duties because of drinking? Do you drink alone? Do you feel the need of a drink at a definite time of the day? Do you have blackouts or periods of amnesia during your drinking bouts?

Do people who care for you criticize your drinking?

I think this last one is a very important sign, because the alcoholic is the last person to see that he is having trouble.

Everyone else seems to see it before he does. And very often he resents criticism by a spouse or a child or someone else. He rationalizes his drinking, gives you good reasons why he drank more than he should or why he drinks in the morning, or why he takes three or four cocktails before lunch, and continually challenges you: "Am I any different from all the friends I go with?" But it's also true, these very friends may be just as alcoholic as he is.

Dr. Marvin A. Block, a practicing internist of Buffalo, N. Y., is vice president of the National Council on Alcoholism and served 10 years as chairman of the American Medical Association's committee on alcoholism. Internationally recognized as an authority on problem drinking and pioneer in modern methods of treatment, he has written and lectured extensively on the subject.

7 WARNING SIGNS OF ALCOHOLISM

A person is in danger, says Dr. Marvin A. Block in this interview, if he—

1. GOES ON FREQUENT DRINKING SPREES.
2. DRINKS THE FIRST THING IN THE MORNING.
3. MISSES TIME FROM WORK BECAUSE OF DRINKING.
4. DRINKS ALONE.
5. FEELS THE NEED OF A DRINK AT A CERTAIN TIME OF DAY.
6. HAS BLACKOUTS OR AMNESIA DURING DRINKING SPREES.
7. FINDS THAT PERSONS CLOSE TO HIM ARE CRITICAL OF HIS DRINKING.

Do you drink alone? And by that I mean, do you take a bottle and sit and drink by yourself? That is a dangerous habit.

Q You mentioned some other signals to watch out for—

A There's one other very revealing and dangerous sign: the blackout.

Now, I want to distinguish the blackout from passing out. Passing out is overanesthetization, which we see when someone drinks too much. And he just passes out. He goes to sleep because of the anesthetic.

But a blackout is a period of amnesia, a period of inability to recall, or loss of memory, during a drinking bout, where there is a blank in the individual's memory. He walks, talks, acts, but doesn't remember it.

This happens very often with heavy drinkers. And many of them tend to discount it as unimportant. But this is one of the cardinal, early signs of alcoholism and should be heeded very carefully. And if anyone has a blackout during his drinking periods, he should immediately consult a physician.

Q Are there other early indications of alcoholism people should look out for?

A Here are some more early signs: Do you drink before you have an important problem that you must tackle? Do you find that you **need** a drink?

Never should one need a drink. And if one does need a drink, that's the time not to drink. The need for a drink at a certain time of the day is also one of the early indicative signs.

Q Many people feel that if you don't drink before five o'clock, you can't be alcoholic. Is there anything to that?

A Nothing at all. As a matter of fact, there's now a wrist watch on the market which has all 5s for the man who never drinks before 5. Very funny. You see how common the superstition is, so that they can make a watch for that.

No, there is nothing to that at all. Some people feel if they drink only beer they will run no risk of alcoholism. Now, this is also wrong, because alcohol is alcohol regardless of the vehicle in which it comes. So that one can be just as alcoholic on beer as one can on wine or on whisky.

ARRESTING ALCOHOLISM—

Q If a person spots any of these signs, can he or anyone, arrest alcoholism?

A Actually, if one gets the signs early enough and the individual is re-educated not to use alcohol as a drug, then I think it may be possible for the problem drinker to drink normally, because he has not yet become addicted.

However, if the disease is allowed to progress to where he loses control, then we have the addict, and then it is not reversible.

Q Is there an average time that it takes to develop into an alcoholic?

A No. This can happen at any time. Some persons are alcoholics from the very first. Some become so after three or four years of drinking. Some will take 15 to 20 years. And some will be alcoholic for years and years and years and never have too much trouble from it.

It varies with the resistance of the individual to the toxic agents, how much he eats or drinks, and how much he cares for his liver, and so on.

Q Is there anything to the idea that a tendency toward alcoholism is hereditary?

A We do know that most of the alcoholics that we see, most alcoholic patients, tell us that they had one or both parents alcoholic.

Now this doesn't mean that the disease is hereditary. It does not come down in the chromosomes or the genes or the tissues at all. But it means that it is communicable.

In other words, the atmosphere of a home where there is an alcoholic is such that it is conducive to the children becoming alcoholic because of the tensions, the insecurities, the unhappiness, the bickering that goes on, and the example that the parents set.

We know that children learn more from what their parents **do** rather than what their parents **say.** There's a tendency on the part of children to follow in their parent's footsteps and their patterns of living. Even if they feel that it isn't good, eventually they do follow these patterns. A parent has tremendous responsibilities to behave in certain ways if he wants his children to come out well-adjusted to the problems of living.

It's a very strange thing that a parent will be very careful about allowing his child to drive an automobile. Not until the child has been instructed, told about the responsibilities, is able to use his judgment, has had a good deal of practice, will the parent allow him to take out his automobile. The child might injure himself or someone else or crack up a $4,000 investment.

But he'll let his child go out and learn how to drink from the boys without preparing him for what it's like, or even watching how he does it.

WHEN TEEN-AGERS DRINK—

Q Are teen-age beer parties a danger from the point of view of creating alcoholics?

A For most youngsters, they would not be dangerous. But we must bear in mind that about 10 per cent of all alcoholics are alcoholic from their very first drink—that is, from the first time they drink anything, they drink excessively.

The individual who falls into that 10 per cent doesn't know that he's in that 10 per cent. Therefore, if he goes on these beer parties and he does get drunk, he's accepted along with the other drinkers just as a normal drinker, so to speak. He doesn't know that he's alcoholic because his behavior isn't too different from the others at the start. So that this individual is likely to go on with beer parties during his student days. And he may go on with heavier drinking for many years before it's discovered that he's an actual alcoholic.

Q How does it go so long undetected? Can't you tell an alcoholic just by looking?

A Not by looking at them—only by exhaustive examination. And this takes a great deal of honesty, and very often the patient will evade it.

I believe not only in interviewing the patient, but his spouse or members of his family as well. Sometimes when you hear the patient's story of his drinking

and then hear his spouse's story, you'd never know they were talking about the same person.

Q Is the general notion of an alcoholic wrong, then?

A The image of the alcoholic in the mind of the average individual is the skid-row bum. They still seem to think that this characterizes the alcoholic. Actually, this type of alcoholic represents but 3 per cent of the alcoholic population.

The other 97 per cent are people that you see every day, with whom you eat in restaurants, whom you see next to you in the theaters and the libraries and everywhere else you go among your friends, relatives and other associates.

So one must understand that one cannot recognize an alcoholic by looking at him. This is the important thing we must recognize: Alcoholism, as every other disease, is very insidious, and, in the beginning—which is the time to get it—it is very difficult to recognize.

That's why it behooves everyone to be on the lookout for his drinking pattern to see that he doesn't drink too much at any time.

END RESULT: DEATH—

Q What happens if alcoholism is not treated?

A Every alcoholic, if he doesn't do something about his disease, will die from it or a complication of it. But maybe not on skid row.

Q Why not?

A Many of them don't end up on skid row because they have families that take care of them. But a greater percentage than that end up in hospitals with cirrhosis of the liver and die long before they reach skid row.

Q Is the liver the organ principally attacked by execessive alcohol?

A Alcohol can attack all of the organs, but the liver is the detoxifying organ, and, of course, this is what suffers most, because all toxic agents must come through the liver. Practically everything we eat and drink goes through the liver, and this is where it is handled. It's a tremendous laboratory of the body, and if that is disturbed by this toxic agent, that is what suffers most.

Q Does the brain suffer damage, too?

A And the brain also does, because the brain is affected by an anesthetic agent—any anesthetic—and, of course, alcohol is an anesthetic, as I said before.

Q Does alcoholism mostly afflict persons of middle age?

A There is no age where you are past the danger, because I've had alcoholic patients 86 years old.

When I first started in this field, the average age we saw the patients was between 45 and 55. About 10 years ago we found most of them between the ages of 35 and 45. Now we're finding a tremendous number between the 25 and 35-year-olds, because we are getting on to the early signs. And, what's more, as education goes on, the stigma is being removed.

They are willing to come in and be listened to and be examined and diagnosed, because they themselves are afraid that they might be alcoholics.

Also, we are beginning to use the same preventive measures that we use in everything else. For people who don't come in for that particular problem, we are beginning to ask about their drinking patterns, and so we're beginning to discover them a lot earlier in the disease. And this should continue until we get them at the very inception of alcoholism, which might be in their teens or their 20s, because we see a great many in their 20s—surprisingly.

Q Has the problem of alcoholism in this country grown more acute in recent years?

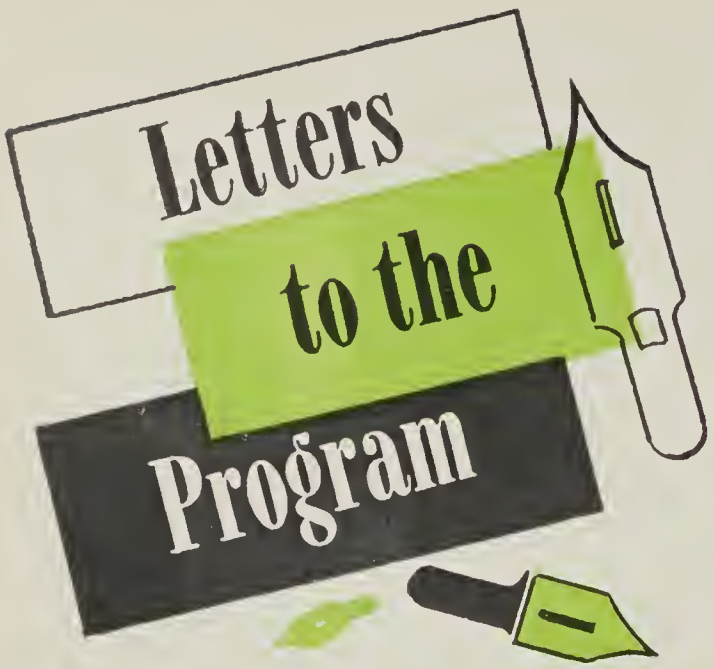
A Well, the percentage of alcoholics in the country has not risen perceptibly in the last few years. But the number has risen as the population has increased.

I would say this: that one out of every 15 of our children under the age of 18 will become alcoholic unless we teach them not to rely on alcohol as a drug, an emotional crutch, which it can be.

Q How many people would you say are now alcoholics?

A There are estimated to be more than 5 million alcoholics in the coun-

(Continued on page 28)



Copies for Binding

We would like to bind our copies of *Inventory* but find that we do not have the issues, Volume 13, Numbers 1, 2, 3 and 6. Would it be possible to obtain copies of these issues?

William C. Smith, Superintendent
Personnel Training Center
N. C. Prison Department
Sanford, N. C.

Working With Parents

Your publication, *Inventory,* was recommended to me by Dr. Kendis who specializes in the treatment of alcoholics. I too feel that it would be helpful in working with the parents of some of the children I counsel with.

Kenneth L. Beals
Child Welfare Worker
Missouri Baptist Children's Home
Bridgeton, Missouri

Church Mission Work

As associate pastor of our church I have charge of the mission work of the church, and I am often in touch with alcoholics. I would like very much to be put on your regular mailing list.

Charles Pool
First Baptist Church
North Wilkesboro, N. C.

Texas Pastor Writes

Several articles in the November-December, 1964 *Inventory* were on themes which have been of interest to me for the past 15 years. By a strange chain of incidents, I became involved in trying to help a group of families who were having a variety of problems and discovered that there was an alcoholic in each family. We started an A.A. group for the alcoholics and case studies of the wives which led us to print the first edition of "Alcoholism, the Family Disease," now used by Al-Anon.

In counseling the families of alcoholics, I like to give them literature which will increase their insight into their problem. The above issue answers many of the questions which are most frequently asked.

Could we have 12 more copies?

Harold Black, Pastor
First Presbyterian Church
Jacksboro, Texas

Requests Materials for Workshop

We plan to conduct a workshop on alcoholism in our school which will involve about 125 junior and senior high school students. I will appreciate any materials you have that might help us with this workshop.

We plan to utilize films from the N. C. Health Department and several people on our staff who have had training in alcoholism.

J. L. Parrish, Principal
Juvenile Evaluation Center
Swannanoa, N. C.

Appreciates Inventory

If I can continue to receive *Inventory* even though I live outside North Carolina, I will show my appreciation by submitting an article on "What the Serenity Prayer of A.A. Means to an Alcoholic."

Anonymous
Richfield, Minnesota

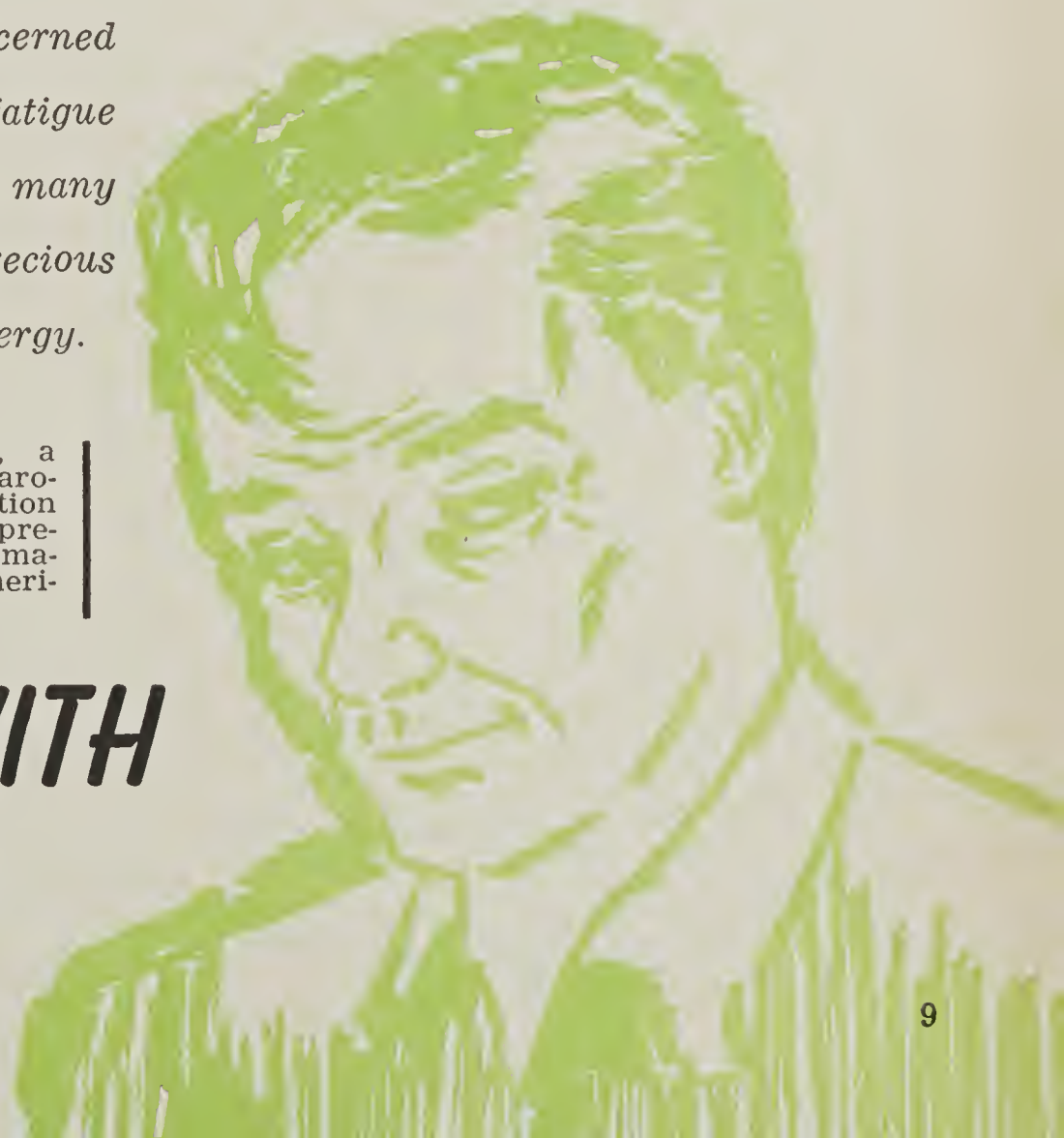
VOL. 14, NO. 6 INVENTORY MARCH-APRIL, 1965

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

FATIGUE is recognized as one of the most common of all complaints that patients make to their physicians. Every day, every hour, in almost every doctor's consulting room he will hear someone say in effect, "I'm too tired and exhausted so much of the time. Please tell me what is wrong."

Strangely enough, fatigue, often described as that extremely tired feeling, does not confine its effects only to a certain age or class of people. Instead it affects people of all ages, either sex, both rich and poor, young and old including all professions and callings. Fatigue influences many aspects of our modern society and, in particular, engraves its indelible mark on about all phases of industry. The plant physician, the flight surgeon, the methods engineer, the equipment designer, and countless others including top management are vitally interested in the role that the interactions of environment play on people's lives, health and dispositions. They would like to know more about the nature of this common malady since fatigue is believed to be a contributing cause of countless accidents from those in the factory and shops

We should all be concerned with ways to eliminate fatigue because it is robbing too many of us of our most precious of resources—human energy.



Reprinted from *Lifelines,* a publication of the South Carolina Alcoholic Rehabilitation Program, this article was prepared by the staff from materials provided by the American Medical Association.

COPING WITH FATIGUE

to highways — even airplane accidents. Fatigue can cause errors in judgment, sub-standard work and insufficient performance. It can put nerves on edge, provoke arguments, trigger quarrels and fights. Fatigue has been a contributing cause of much tension, frustration, friction and irritation. It has played a leading role in breaking up friendships, partnerships, and marriages.

It is somewhat difficult to measure the full extent or degree of fatigue or to arrive at its exact true cause, since no two human beings are alike or have the same energy resources and reserves. Also the capacities of individuals vary from day to day. But we do know that today fatigue is robbing entirely too many of us of our most precious of resources—human energy. So we should be concerned and interested in ways to eliminate it so as to get more out of life and with much less strain.

The things that different people can do without becoming exhausted vary greatly. And the energy output of one person under one set of circumstances compared with the way he handles exactly the same task under different conditions also varies. A business executive may go through his work with almost superhuman speed one day; on another, when he is beset with emotional problems and irritations, he may literally worry himself into exhaustion before noon, with very little work accomplished.

Robert S. Schwab, M.D. of Boston tells us that, "often tiredness is out of proportion to the energy spent; and it may not disappear with rest, sleep or a vacation." Furthermore, frequently you are far more tired than you realize. And for a surprisingly long time you may do a fairly acceptable job, simply by calling on your will power to keep the energy-controlling thermostat at a high level. But if continued too long, it causes over exertion of the body or brain, or both, and body movements lose dexterity and become automatic. Your mental processes may then tend to become stereotyped—imagination lags, conscious attention waves appreciably, judgment suffers —in fact your whole personality may experience a noticeable change.

According to *Today's Health*, a publication of the American Medical Association, it is the tired person that loses his poise, his social graces and, to a marked degree, his dispostion. It is the habitually tired person that becomes a victim of chronic fatigue, one of the most serious threats to health and happiness.

What is fatigue? A common interpretation of fatigue is a state of increased discomfort and decreased efficiency resulting from prolonged or excessive exertion. However fatigue or an excessive tired feeling may not be a result of work or physical exertion. A soldier may experience fatigue by standing still and at attention for a long period of time.

Even when something as commonplace as inadequate working space or quarters are believed to be a cause of fatigue for some people. Lillian Galbraiths, D.Sc., an authority in her field, found that cluttered working or living quarters were often responsible for both physical weariness and psychological debility. The reason: Lack of elbowroom causes frustration. And frustration is often more to blame for fatigue than overwork.

Mrs. Galbraiths found that coloring of walls, drapes and surroundings affected some p e o p l e adversely, especially women. She found that glare is even more fatigue-provoking than unrestful colors. "Usually we are quick to notice any major source of direct glare," she said, "and to do something about it—to move an of-

fending mirror or adjust a window shade. But we often overlook more subtle, and thus more insidious sources of glare. An uncomfortable chair, desk or table may wear a worker down with equal effect." Noise is another cause of fatigue. It is an established fact that one's physical surroundings, as well as the type of work one has to do, along with one's activities and even one's associates and coworkers have a bearing on the degree of one's tiredness.

Fatigue may be divided into three separate categories: 1) *Pathological fatigue*—often an early symptom of some serious organic disease. 2) *Physiological fatigue*—from chemical reactions in the blood that leave the muscles of healthy people exhausted. 3) *Psychological fatigue*—from prolonged emotional conflicts, anxiety and boredom (the most common).

Check With Doctor

Anyone who is chronically tired should check with his doctor for serious cause of fatigue since the extremely tired person who is sure there is something radically wrong with him may be right. However, far more often it is psychological fatigue from which patients suffer. Dr. Frank N. Allan, a Boston internist, in his study of 300 victims of chronic exhaustion found that only 20 per cent were tired for purely physical reasons. The other 80 per cent were experiencing emotional problems of varying degrees.

Yet, paradoxically, we all know people who seem to be immune to fatigue. Even when weighted down by physical or mental exertion, these "high-energy" individuals apparently never complain of being tired. Optimistically, decisively, and exuberantly, they seem to manage to keep several projects going at the same time—and with vigor to spare.

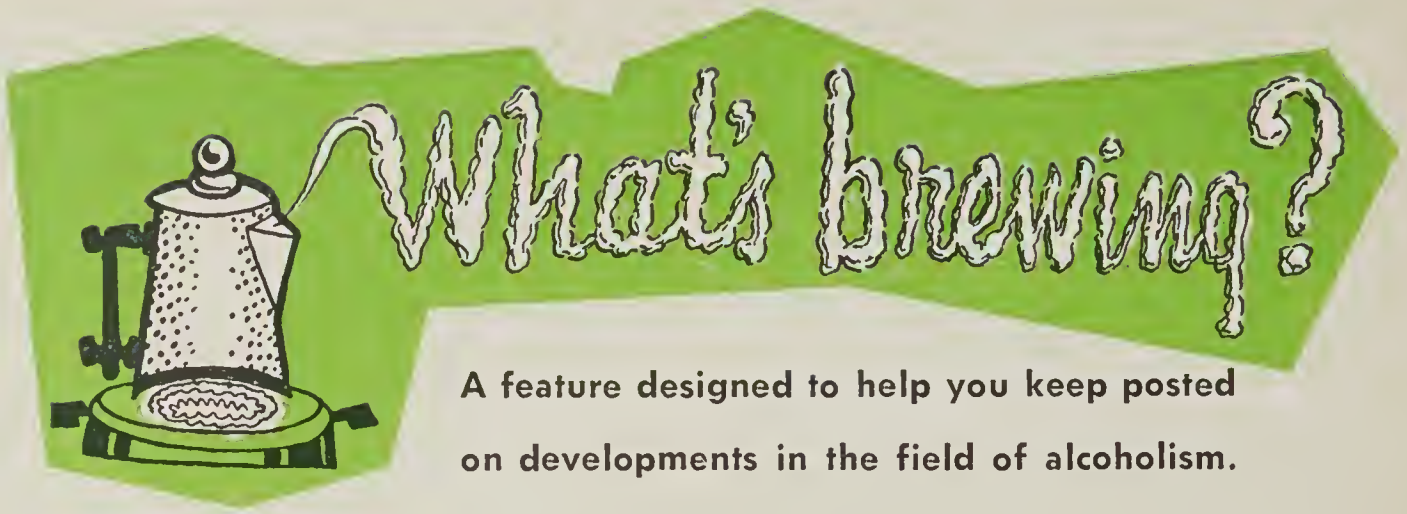
Why do some individuals seem to have almost limitless mental and physical drive while others seem to tire after the least exertion?

Hans Selye, M.D., internationally known endocrinologist believes that each of us inherits our fatigue pattern. He suggests that each of us should appraise our own energy store —that we should ask ourselves serious questions, such as: 1) What are the main stress factors in our lives? 2) At what time of the day or night do we have the most energy? 3) When fatigue strikes us, how long does it last? 4) How long can we keep adapting to trying circumstances without growing weary? Once you have established your fatigue pattern, Dr. Selye advises "try to space out jobs, and reserve energy-demanding tasks for the time when you have the greatest strength. Also, it is important to change pace. If too tired to think well, stop and walk around a bit; if muscle-tired, sit down and think, or listen to music."

High-energy people are most likely to overcrowd their lives with enticing new projects as well as responsibilities, and Dr. Selye has this word of warning for them. "A person may be intoxicated by his own stress-fighting hormones—an intoxication that can cause more harm than alcohol." He warns that even though you love every moment of your work, you could be over-stimulating your adrenal glands and advises you to watch out for your critical stress quota. Once in a while, re-examine your fatigue pattern to see if you are exceeding the limit.

Researchers have spent many years looking for clues to the mechanics of fatigue. And they have learned that physical fatigue is caused by a complex chain of chemical reactions. Investigators found that,

(Continued on page 14)



A feature designed to help you keep posted on developments in the field of alcoholism.

NEW BERN, N. C.: "Toward Better Understanding" will be the theme of two workshops for ministers, social workers and public health nurses from seven counties. Sponsored by the Craven County Council on Alcoholism and the Craven County Mental Health Association, the workshops will be held March 29 and April 29 in the fellowship hall of the First Presbyterian Church, New Bern. The participating counties are: Craven, Pamlico, Jones, Beaufort, Carteret, Lenoir and Onslow.

NEW BRUNSWICK, NEW JERSEY: The 1965 Summer School of Alcohol Studies at Rutgers University will have two main aspects—a Physicians Institute for medical men who wish to be informed about current research and clinical practice in alcoholism and a series of 13 training courses in specific areas of alcohol studies designed for medical personnel, social workers, teachers, public health personnel, community organization workers, labor and management personnel involved in the development of industrial alcoholism programs, rehabilitation and correctional officers, clergymen and others whose work or training has acquainted them with alcohol problems. More than 4,300 students have attended the school since it was founded in 1943 at Yale University. This will be its fourth year of operation at Rutgers. The Physicians Institute will run from June 27 to July 9 and the training courses will run from June 27 to July 16. The deadline for applications is May 1. Dr. Milton A. Maxwell is executive director of the Summer School.

Rutgers—The State University also offers the Northeast Institute (July 18-23), an orientation course for those without special training or experience in the field of alcoholism.

1965 SUMMER SCHOOLS: Summer Studies on Facts About Alcohol, a short course for teachers and prospective teachers, will be conducted at East Carolina College, Greenville, June 8-18; North Carolina College, Durham, June 7-19; and Winston-Salem Teachers College, Winston-Salem, July 6-23. Co-sponsored by the colleges and the Education Division, N. C. Department of Mental Health, the courses carry college credit. Applications for admission should be addressed to the Director of Summer Session at the college selected.

The third annual Summer School of Alcohol Studies, co-sponsored by the Education Division, Alcoholism Programs of North Carolina, and the Department of Health Education, School of Public Health, University of North Carolina, will be held at the University of North Carolina, Chapel Hill, June 20-25. This course, conducted for key community workers such as health, welfare and law enforcement personnel, court officials, nurses, social workers, physicians, alcoholism program workers and other interested people, does not carry college credit. Some scholarships are available through local programs and the Education Division of the N. C. Department of Mental Health.

TORONTO, CANADA: The 30th Anniversary International Convention of Alcoholics Anonymous will meet in Toronto, Canada, July 2-4, 1965 at the Royal York Hotel. According to the A.A. Exchange Bulletin, the first 100 members are being searched out for participation in the convention—quite a big job in an anonymous outfit with no lists of members! Those attending will hear the A.A. message in many tongues with simultaneous translations. Bill W., a co-founder, will be on hand plus many other early A.A. members. Al-Anon will meet concurrently at another hotel.

BUFFALO, N. Y.: Dr. Marvin A. Block, an internationally recognized authority on alcoholism, has advanced a new theory on alcoholism, according to the Washington Post-Los Angeles Times News Service. Dr. Block says that the alcoholic may need alcohol in much the same manner that the diabetic requires insulin. Alcoholism, Block said, can cause cell changes, particularly of brain cells, that become so altered that the cells require alcohol to function. Without alcohol, the deprived cells act up, producing convulsions or just the plain "shakes." He said prolonged exposure to alcohol, which leads to alcoholism, affects the fluidity of cells, particularly the brain cells. For the social drinker, the changes are transitory; for the alcoholic the changes become permanent, and demanding. Dr. Block is vice president of the National Council on alcoholism and ex-chairman of the American Medical Association's committee on alcoholism.

ALCOHOLISM LEGISLATION—SENATE BILL 108: Senator Walter Jones of Pitt County has introduced before the 1965 Session of the North Carolina Legislature a bill (SB 108) to provide for establishing and financing voluntary alcoholic rehabilitation centers in Eastern and Western North Carolina. SB 108 also includes a provision for improvements in the existing Alcoholic Rehabilitation Center for voluntary patients at Butner, N. C. which has had to serve the entire state. However, as has been pointed out by Dr. Norman A. Desrosiers, medical director of the A.R.C., it is a known statistical fact that the alcoholic who seeks help voluntarily will not, with rare exceptions, travel over 150 miles from home for treatment. This means, in effect, that the A.R.C. has not really been serving the entire state, but only that portion within a 150 mile radius of Butner. The placing of voluntary treatment centers in carefully selected locations in Eastern and Western North Carolina could remedy this discrepancy and put voluntary treatment for alcoholism within 100 miles of **all** citizens who may need it. Another statistical fact from the experience of the A.R.C. which sheds light on the advisability of making more beds available in strategic locations is that chances are one out of two that the patient who has to wait more than a few days for admission to a voluntary treatment center will not appear. This, according to Dr. Desrosiers, is a remarkably constant fact in dealing with the illness of alcoholism. "Ideally," Dr. Desrosiers says, "there should be no waiting list for the voluntary alcoholic. Half of them are lost to treatment if a week's time is lost." SB 108 proposes that the building, improving and operation of the centers be financed through a five cents per bottle increase in the retail price of all alcoholic beverages sold in A.B.C. stores throughout the state.

Another crucial fact to consider is the sheer size of the alcoholism problem. Even with two additional voluntary treatment centers there would only be enough beds (including the beds available in state mental hospitals for the treatment of alcoholics) to accommodate roughly 1/7 of the estimated alcoholic population in North Carolina. Even so, it is felt that this will be enough beds for adequate services to those alcoholics who will need inpatient care provided adequate outpatient treatment services are developed.

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if the human body is to carry a reasonably heavy work load without exhaustion, complete coordination of mental muscular movements with breathing and circulation is necessary. Your muscles rely on glycogen, the energy-producing material, for their power to contract. But, after prolonged muscular effort, the so-called "fatigue materials"—lactic acid, carbon dioxide and other by-products —seep into the bloodstream. (Injections of blood from a fatigued animal into a rested animal will produce fatigue.)

Your metabolism is regulated by your endocrine glands. Of the endocrine glands, the two adrenals, located like tiny valves on top of each kidney, are the most reliable aids in rallying the body for the fight against fatigue. The immediate response to heightened emotions—such as anger, fear, and anxiety—is stepped up adrenal-gland activity. Adrenalin helps the liver to liberate sugar; it also increases the rate and force of heartbeat and, thereby, the flow of blood into the tired muscles. When bits of this powerful hormone are released, the whole body is made ready for immediate physical and mental action—"fight or flight."

Extreme fatigue has the opposite effect on the glandular system. When you are excessively tired, your output of adrenalin hormones is greatly decreased, almost to a standstill.

In stress studies made of many employees, it was found that the higher the person's skill, the less his fatigue, and the smaller his increase in adrenal output. It was found "the more secure performer needed to call less on his adrenal glands to meet the demands of the situation." This may explain why some exceptionally gifted people seem tireless.

Endocrine studies also explain "the second wind," that unexpected surge of muscular energy under stress. This increase is caused by action of the nervous system on the adrenal glands by a sudden release of adrenalin into the tired person's blood.

"What rest will do after an hour or more, adrenalin will do in five minutes or less," commented a gland specialist. "But the increased efficiency of the second wind is temporary. The production of adrenalin to take care of fatigue emergency cannot be substituted indefinitely for normal rest and sleep.

Imaginary fatigue, to avoid work or some painful activity is a common ailment, and most of us have resorted to it more times than we realized. James Boswell, in his biography of Samuel Johnson wrote that "when faced with work, Johnson was sometimes so tired, languid and inefficient that he could not distinguish the hour upon the clock."

Just before Robert Schumann would begin the tedious task of composing a new concerto, he "was seized with fits of trembling, fatigue and coldness of the feet." Charles Darwin's son, Sir Francis, wrote that when his father thought about an extremely hard task, a long journey or a public apperance, he often became fatigued to the point of illness.

Many celebrated personalities were victims of "motivational fatigue." They were extremely gifted but they seem to lack the incentive to adapt themselves to their callings with courage and patience. Doubtless most of them had adequate stores of physical and mental energy but their zest had waned, their interest in their work vanished, and it seemed simpler and easier to retreat into exhaustion than to try to revive their will-to-do. This is a form of

fatigue or tiredness that afflicts thousands of less talented men and women in all walks of life who have chosen to withdraw from their inner conflicts and from active participation. And withdrawing causes the death of their zest for achievement.

While fatigue may be produced by tensions, emotional strains and worrying, curiously enough it can be relieved by good news or by the anticipation of future pleasures. In a study of a large number of industrial workers, it was found that at the end of the day, some of the laborers looked as though they were ready to drop with fatigue. Yet others doing the same work for the same length of time appeared exuberant and full of pep and bounce. What was the mystery? None—except the lively ones were looking forward to some sort of evening activity. Many people would find their work less fatigue-producing if they had more outside recreation and activities. Most of us require at least some diversion. The trouble is, too few get it.

Fatigue, actually, is not as bad as it is sometimes pictured. It does not change our capacities—it merely diminishes them temporarily. If we will learn to recognize the symptoms of exhaustion and try to do something about them, fatigue can be a fine education. It can teach us how much we can get out of our body machinery, what the signs of overstrain are, and what to do about them. After all, it is up to us to be everlastingly alert—to learn to eliminate as many of the fatigue producing incidents and elements as possible—and to put into our minds, as well as the minds and lives of those about us, as much as we can of the magical and helpful attitude which makes every day seem *the best yet.* Emerson was right when he wrote, "the world belongs to the energetic."

WHAT'S BREWING?

The outpatient treatment services in question are of two varieties: in lieu of inpatient treatment and follow-up after inpatient treatment.

The passage of SB 108 would make the development of outpatient services pertaining to "follow-up after inpatient treatment" more feasible. Centers that are accessible to patients for inpatient treatment are also accessible to patients for any follow-up outpatient treatment service they may develop. Also, the closer proximity of the centers to the mental health and aftercare clinics in the areas they serve would make possible closer cooperation in the use of these resources for aftercare follow-up treatment.

In regard to outpatient treatment services "in lieu of inpatient treatment," there is a large school of thought which suggests that a large percentage of the alcoholic population can best be treated in their local communities if even a single competent person is located there. The Education Division of the Department of Mental Health has demonstrated a direction that this development could follow. Through its outpatient budget, it was able to financially assist the Craven County Council on Alcoholism in the employment of a qualified psychiatric social worker to work exclusively with alcoholics. As a result of this social worker's efforts with alcoholics and their families, the number of persons from this area referred to the A.R.C. for inpatient care has dropped precipitously.

SB 108, if passed, will provide the voluntary treatment centers. The budget request of the N. C. Department of Mental Health, if granted, will provide the impetus for development of adequate outpatient treatment services. The outcome rests in the hands of North Carolina legislators and, through them, the people of North Carolina.

A public health nurse tells how one woman was able to utilize her services in gaining insight into, and alleviation from, her drinking and associated problems.

FOR some time, public health nurses have been pointing out that they have a role to play in helping alcoholics and the members of their families. They have noted that the nurse is in a unique position to help. She is less threatening yet can offer skills, information, and a safe objectivity which friends, however sympathetic, cannot give.

Several years ago, the Mental Health Division of the Toronto Department of Public Health initiated a new program in mental health nursing. The primary function of these specially trained public health nurses is an advisory one to staff, as well as case finding, referrals and counseling To date, there have been five such nurses assigned to five of the health districts in the city; two other nurses are at the University of Toronto; and it is expected that another will go to the university next year. This will make it possible to have a mental health nurse in each of the eight districts.

The following was submitted by Mrs. Jean Uzumeri, a member of the staff of the Toronto Department of Public Health with this advanced preparation. She obtained the permission of the patient for sharing this story. (Addictions)

Reprinted from *Addictions,* published quarterly by the Alcoholism & Drug Addiction Research Foundation of Ontario, Toronto, Ontario, Canada.

Can The Public Health Nurse Help?

COUNSELING in the home is one facet of the service offered by a mental health nurse. It is hoped that this case history will demonstrate the way in which one woman, Mrs. A., was able to use this service to gain insight into her drinking problems and utilize this insight to alleviate some of her associated problems. The original referral was made by a married girl friend who described Mrs. A. as being depressed, preoccupied, unable to make decisions and excessively fatigued following the sudden and fatal heart attack of her husband. However, it was four months later following six telephone calls and two home visits that drinking was identified as being Mrs. A.'s central problem.

Mrs. A. is a short, thin, immaculately groomed, attractive widow in her late thirties who speaks in a well modulated voice and smokes excessively. At the time of the first home visit she appeared agitated, frequently tearful, but anxious to discuss candidly her past life and current problems. Her present family consists of Donald, a 17-year-old son by her first marriage, and Dianne, 4 years old, reportedly having to manage for herself because Mrs. A. was too preoccupied to provide supervision.

Mrs. A. came to Canada in 1945 as an English war bride. Of her family, still all in England, her father is described as a heavy drinker who created such havoc in the home that Mrs. A. was determined to marry a man who didn't drink. Her first marriage to a man who took only an occasional social drink was reportedly happy. However, five years later he died of Hodgkin's disease, following an illness of several months. Left with very little money, a young son, no relatives in Canada and few friends, Mrs. A. found it difficult to resist the attentions of a personable, apparently affluent young man, although she realized that he was a heavy drinker before they were married. This second marriage was marred by heavy drinking, frequent fights aggravated by conflict over the handling of money and children and several attempts of Mrs. A. to commit suicide. Donald resented this second marriage, and established a pattern of passive resistance to his stepfather by refusing to do the chores expected of him

BY JEAN UZUMERI

MENTAL HEALTH NURSE
TORONTO DEPARTMENT OF PUBLIC HEALTH

around the house. Where Donald was punished by the stepfather by being given less money and little attention, both parents lavished money, gifts, and attention on Dianne. This pattern of equating love with money seems to have been adopted by each family member.

During the initial visit, Mrs. A. was encouraged to talk about her problems. She complained of a severe cough, loss of appetite and insomnia. She noted in herself a need to lean on others. She recognized that her loneliness was not only for her deceased husband but for her son now away at camp and from whom there had been no letter. She pointed out her pattern of trying to escape her problems by suicidal attempts on two or three occasions. She seemed quite shaken by a recent episode where she had taken an overdose of barbiturates, fallen asleep while smoking and had burned the mattress. In addition, she was deeply concerned about a dwindling bank account and debts incurred by her husband.

The nurse saw Mrs. A.'s problems initially as a grief reaction to the death of her husband upon whom she had been dependent, guilt surrounding her own relief at the termination of an unhappy marriage, loneliness for her son from whom was separated for the first time, poor health and financial difficulties.

Mrs. A. wanted help. Since she and her children had recently moved to Toronto from a Southern Ontario town, she had no family physician, few friends, and no knowledge of community facilities. She was urged to seek medical attention at once. Her friend, who had made the original referral for help, apparently was a source of great support. This relationship was encouraged and the suggestions offered by the friend in regard to her financial problems were supported. The nurse maintained telephone contact every week for two months with both Mrs. A. and her friend. Mrs. A.'s mood lifted rapidly. She obtained full-time employment as a waitress, selected a private doctor who prescribed medicine for her "nerves," moved into a more economical flat and took a renewed interest in her children. At this point, with Mrs. A.'s health and social problems apparently alleviated, the case was considered inactive. No further contact was made until Mrs. A.'s friend again called a month later.

This second referral was made because Mrs. A. had been drinking excessively, had again become depressed and was suffering from a heavy cold. When a home visit was made, Mrs. A., now pale, shaky, composed and sober, described candidly how she consumed in 48 hourse, three bottles of liquor (rum, cherry brandy, and vodka). She attributed this binge to a desire to escape a series of unpleasant events, the recent death of her father, fatigue as a result of overtime work, ill health, and a frustrating encounter with her in-laws. Above all else was her concern and worry over Donald with whom she was quarreling frequently.

Little Insight

Mrs. A., although intelligent and anxious for assistance, had little insight at this point into her problems. On an intellectual basis she recognized the fact she was overindulgent with Donald, trying constantly to compensate for the "bad years" of her second marriage. On the other hand she expected him to fill the vacant husband role. In exploring community facilities available, it became evident that she could accept guidance most readily if it were offered in relation to Donald, rather than in relation to herself. Therefore,

it was not surprising that she rejected the Family Service Agency in favor of a referral to Child Adjustment Services. Mrs. A. was advised to call for an appointment, but it was several months before she actually accepted this proposal. She saw little significance in her pattern of living—the relationship between her drinking, fatigue, overwork, illness and compulsive housekeeping habits. Her drinking, she was inclined to shrug off as "just a binge," and was unable to view it as a major problem. The nurse telephoned the Addiction Research Foundation, but Mrs. A. found the long waiting list an overwhelming obstacle to seeking help there.

The nurse, with Mrs. A.'s consent, contacted the private doctor by telephone and forwarded a written report in an effort to acquaint him more thoroughly with some of Mrs. A.'s problems. Mrs. A. attended him regularly and again regained a feeling of well-being. She returned to work, at first insisting on shorter working hours, but later accepted more and more overtime work. She maintained her high standards of housekeeping. She retained her expensive tastes although her income could not support them and as a result her bank account continued to dwindle.

There was little doubt in the nurse's mind now that Mrs. A. had a drinking problem. Home visits were continued every two weeks, and it was during one of these routine visits that Mrs. A. was finally discovered on a drinking bout. The nurse spent the better part of the next three days in the home, as follows:

First Day: The living quarters which were usually immaculately neat and clean were in a state of disorder. Dirty dishes, overflowing ashtrays, empty bottles, dirty clothes and evidence of vomiting were everywhere. Mrs. A., scarcely able to sit up, nauseated and groggy, was sprawled half-dressed on the chesterfield. The five-year-old daughter, grotesquely attired in what she could find for herself, was trying to forage a lunch. Seventeen-year-old Donald was in bed, trying to escape the whole situation by convincing himself that he had the "flu."

The nurse put on a pot of coffee, dressed Dianne, and arranged with the landlady to provide care for her during the day. Donald was offered symathy in his illness. His temperature was taken (which was normal), he was encouraged to gargle his throat (which was not red) and then we sat down for a long discussion. He related in detail the events leading up to his mother's present condition. He was encouraged to verbalize feelings surrounding this episode and then attempts were made to help him see his mother as a sick woman, rather than "bad" or intentionally neglectful. With encouragement and a little concrete assistance, he set about to clean up the apartment. Detailed instructions were left with him, suggesting he get as many fluids as possible into his mother, and he was reassured that the nurse would return in the afternoon. He was also advised to call his school to explain his absence for the day.

It was almost a mother-child relationship between the nurse and Mrs. A. during the first day. Firm, sympathetic but very directive assistance was offered. Mrs. A. alternately cried and begged for help then would turn her face into her pillow refusing to speak. However, with encouragement, she did take three cups of coffee and agreed to cooperate with her son in taking quantities of fluids other than alcoholic beverages. Upon

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Understanding and prevention of alcoholism must start with the social structure and attitudes of our people toward drinking as they are today, not as they were 75 years ago.

Part II

ALCOHOL —Its Social and Educational Implications

By The Late Raymond G. McCarthy

This article is reprinted from the proceedings of a 1963 conference on "Alcohol Education—Whose Responsibility?" (published by the Michigan State Board of Alcoholism) which was conducted under the auspices of the National Institute of Mental Health. The other sponsors were the Michigan Departments of Mental Health, Public Instruction and Health, the Michigan Congress of Parents and Teachers and Michigan State University. The author, the late Raymond G. McCarthy, M.Ed., was executive director of the Rutgers Summer School of Alcohol Studies.

The concept that alcoholism is an illness, that it is not caused primarily by alcohol, that alcoholics are not only sick but require highly specialized professional skills—these concepts appear to be acknowledged by a relatively small proportion of professional people today. In Dr. Trotter's time (19th century) many physicians were of the opinion that alcoholism was an expression of a spiritual defect which could not be remedied by medication. Although this theory has been generally rejected, it has been supplanted by the contemporary notion that alcoholics are essentially weak-willed individuals whose principal limitation is one of character and that there is little in medical armamentarium designed to repair a character defect.

There are few physicians in this country who, at one time or another, have not been called upon to treat a case of acute intoxication, of delirium tremens, or of nutritional disorders resulting from prolonged drinking. Medical schools have offered adequate training to their students to cope with these symptoms. But understanding of the chronic nature of the disorder and the therapeutic requirements beyond relief of acute intoxication would appear to be either conspicuously absent or to have only limited appeal for the majority of physicians.

If you consult a medical textbook, you will find public health diseases analyzed under a series of subheads which include: 1) a definition of the symptoms of the disorder; 2) a statement of the causative agent; 3) a description of the host upon which the causative agent multiplies; 4) the epidemiology of the disease, i.e., the distribution of the illness among different segments of the population; 5) specific treatment, and 6) recommendations for prevention. Obvious-

ly these criteria will vary among different diseases. In general, however, health officers attempt to formulate public health problems within the framework I have described.

When you apply these criteria to alcoholism as a public health problem, serious limitations appear. There is no suggestion of a primary causative agent; symptoms are limited to changes in behavior; and treatment recommendations are omitted because of lack of specificity.

Alcoholism, in my opinion, is a form of illness. Certainly alcoholics are sick people. But I believe that we must acknowledge serious difficulty in formulating preventive measures in the absence of scientifically devised and verifiable factors in the causation and progression of the disorder.

The alcoholic population represents a cross section of our society. The behavior identified as alcoholism proceeds at a different rate, is expressed in different forms by different individuals suffering from the disorder. The illness affects males more commonly than females, in a ratio of approximately 5.5 to 1. These data, combined with the statistics on consumption and rates of alcoholism, suggest that perhaps we have an epidemiology. Actually, the figures are based on a fairly reliable statistical formula developed by Dr. E .M. Jellinek a dozen years ago. The formula, validated by field surveys, has proved to be extremely useful. Yet there are limitations in our knowledge of prevalence. For example, we have no data on prevalence at different socioeconomic levels in our society. We have no reliable statistics on differences among the several age groups, particularly the group most exposed to alcoholism. We have only limited understanding of the incidence of alcoholism, that is, the rate of increase in the number of cases annually. As you know, this is not a reportable illness, and vital statistics are of limited value. As a matter of fact, when alcoholism is a primary cause of death, the physician is often reluctant to indicate this on the death certificate, in order to protect the reputation of the family.

When alcoholism develops in the professional man, does it exhibit the same pattern as that found among unskilled workers and itinerants? If so, what are the identifying characteristics? We have data on the progression of alcoholism, formulated by Dr. Jellinek on the basis of information provided by approximately 100 members of Alcoholics Anonymous. But are these steps always present? Do they appear with a degree of frequency so that they can be postulated as progressive symptoms? Can we focus an educational program of prevention on these symptoms? I am extremely skeptical of this, although I recognize that this may be our only symptomatology at present. What is clear is that both the professional man who is an alcoholic and the skid-row individual have some kind of psychological need to use alcohol and and inability to control the use once they begin drinking. How to identify this need, how to define it so that it is applicable to a substantial number of cases, and then formulate a program of prevention around this difficult area is essentially a problem in emotional health.

The alcoholism literature contains a number of statements on causation, statements based on research in different areas. Many biochemists and physiologists assume that alcoholics may differ from their friends who are not alcoholics in the way the body handles alcohol. They are seeking more biochemical or hormonal difference in the body systems which

would enable us to identify potential alcoholics. It would be a tremendous step forward if this could be accomplished. At the moment we can only report that such research has not been productive. The physiological differences observed among some uncontrolled drinkers are probably the result, rather than the cause.

For the psychiatrist, alcoholism is a symptom of unresolved emotional conflict. This conflict is expressed as tension, as stress, with physiological overtones, and the sufferer learns that small amounts of alcohol provide relief. He continues to drink, seeking greater relief, meanwhile failing to resolve the underlying conflict which is producing the tension. As his drinking increases, new problems arise. For many laymen, alcoholism is disorganization of family life, loss of job, financial difficulty, arrests, and hospitalizations. That these are serious and tragic concomitants of the illness is unquestioned. That they are causes, except in a secondary sense, is not a valid assumption.

Sociologists point to the high degree of social control of drunkenness maintained in those cultures in which alcohol use is incorporated in the social, dietary, and religious life of the group, particularly among the Jews. They do not deny that some biochemical factor may in time be identified as the cause of the condition. However, they believe that social attitudes toward intoxication, toward drunkenness—negative social sanctions against those who persist in using alcohol beyond the limits of the accepted social patterns—will provide the most effective mechanism of control, except for those individuals who are seriously disturbed psychologically.

The interpretations advanced concerning causation of alcoholism are of course influenced by the professional disciplines of the researchers. The biochemist and the physiologist are trained to serach for answers within the body chemistry. The psychiatrist reports what he has observed in his practice in his work with alcoholics. Similarly, members of Alcoholics Anonymous have formulated a theory on the causation of alcoholism which they offer to newcomers and which appears to be acceptable to large numbers of sufferers from the disorder. Most alcoholics reluctantly accept treatment only after a crisis has been reached, a point at which many of the presenting conditions are common for the group. It is unfortunate that early diagnosis is rarely possible, because of popular misinformation and emotional bias.

Pseudo-adjustment

It is my belief that uncontrolled drinking is a form of adjustment, a pseudo-adjustment which provides a temporary kind of relief but inevitably leads to greater problems for which alcohol provides no adjustment. Within the alcoholic population will be found different groups of personalities using alcohol for quite different motivations. One substantial group consists of men and women of considerable personal assets who nevertheless find the depressant action of alcohol on the nervous system peculiarly gratifying. This gratification is beyond the range of that sought by the ordinary social drinker, who, given two or three drinks, can quite honestly assert that he has had enough. The alcoholic repeatedly finds relief from emotional distress, accompanied by greater and greater satisfaction as intake increases. But problems accumulate and finally become so intolerable that he is forced to seek treatment. Then the assets in his personality

which have been blunted or blocked by the uncontrolled drinking are now able to function again. In time he is able to lead a fairly constructive, satisfying life without alcohol, provided he refrains from drinking.

Obviously any program of treatment must recognize different potentials for recovery and different prognoses. Similarly, in planning a program of prevention, are we going to talk about the alcoholic, or rather about a range of people who use alcohol in an uncontrolled fashion, with serious consequences to themselves, their families, and society? These are realistic problems, problems for which science has not yet provided the basic information.

Any broad program of prevention must be focused on the community at large as well as toward professional people and sufferers from the disorder. At our present level of understanding of the illness, no one can predict which of a group of beginning drinkers is likely to become an alcoholic. Obviously there is one surefire preventive technique, namely, to abstain from drinking. But with the wide acceptance of social drinking, with the acceptance among some groups of heavy drinking and intoxication, it is logical to expect that a certain number of vulnerable individuals, vulnerable to the toxic action of alcohol, will lose perspective to a point where drinking becomes an end in itself rather than an accompaniment to social relations. It is my impression that any program of prevention must begin, as I said, with our drinking culture, with an attempt to understand the role of alcohol in our society, and an attempt which will result in raising questions about the relation between social drinking and alcoholism.

A short time ago, I came across a series of observations on community planning which interested me and which I think are pertinent for discussion in this conference. Dr. Murray Ross in his book "Community Organization—Theory and Principles" made the following comments:

1. As any group seeks to bring about a particular change in a community, it must recognize that people tend to cling to the usual for this they understand, since they have always lived with it and adjusted their practices and ideas with relation to it.
2. People will change only when they feel ready for change. The objective therefore, is to create readiness for movement.
3. The pace developed by any community of people may seem extremely slow and yet this deliberate pace permits adaptation both to change introduced and to the many side effects arising from the proposed change.
4. In every community, certain traditional ways of behaving develop which determine to some extent whether the people will participate actively and cooperatively in community affairs, and determine almost completely the manner in which they will cooperate or resist.
5. The discontent which stimulates a group to seek change must be widely shared in the community and must involve leaders identified with, and accepted by, other major groups in the community.
6. No matter how good a plan is, if the community does not feel a responsibility and a desire to participate, it will not work successfully.

I believe Dr. Ross has provided some clues as to what happens in a community education program.

Changes in community attitudes and practices do not come about

overnight. They do not necessarily result immediately from the impact of well designed and promoted public relations. It *is* possible to modify community attitudes and to modify them constructively in the light of our particular area of interest. But I think we must recognize that there are certain principles which apply, certain concepts in communication, in learning theory that need to be examined and implemented carefully if we are to achieve the maximum result from our efforts.

It might be helpful to examine briefly one or two elementary principles of learning theory. When the objective of the educational process involves behavior modification, it is generally acknowledged that maximum results will be achieved when a *need* is present. Learning proceeds most rapidly when the need is gratified—when a reward follows. Whether one speaks of need, or drive, or motivation, there must be a readiness to respond which can be reinforced by some kind of satisfaction following participation in the educational process.

I feel certain that Pavlov's dogs would not have become conditioned to the bell had they been placed in the harness after being fed a substantial meal. Again, I doubt that our experimental psychologists who make wide use of laboratory animals, would think of placing a well fed animal in a skinner box to determine the animal's rate of learning to manipulate a lever or respond to a signal to secure a pellet of food. For these animals to perform with any degree of reliability, an acute physiological need is established and learning rewarded by the securing of food. This, of course, represents need and drive at a fairly instinctual level but it is nevertheless an application of the principle.

While one may be reluctant to project from animal need response to that of humans, health educators recognize that the need concept is just as applicable in their work as it is in the research of the experimental psychologist. For some years health education consisted primarily of making available the facts about disease, sanitation, prevention of illness and effective hygiene. When substantial segments of the public did not respond to such informational campaigns, it was assumed that they were either unintelligent or indifferent to the health needs of themselves, their families and their neighbors. We know that there are a series of screens through which a health message must pass before it can reach some of the groups we are interested in influencing. Moreover, even after the message is heard, it does not follow that there will be constructive action if the recommendations for action are inconsistent with traditional group norms.

Animal experimenters have been interested in conflict. A rat that has learned to operate a switch to secure food will find himself experiencing electric shock when he approaches the release bar. He is caught in the conflict between drive reduction through satisfying his hunger and avoidance of pain inflicted by the electric shock. The manner in which humans handle conflict has long been of interest to those of us in the field of alcohol problems. The health educator, too, has been obliged to deal with highly developed systems of rationalization involving rejection of his health message.

In recent years we have been exposed to reports which suggest a significant correlation between smoking and lung cancer. One researcher has reported studying a sample of non-smokers who have responded

positively to the recommendation to eliminate smoking and another sample that continued to smoke. Each sample represented a cross-section of society. It appeared significant among those who had given up smoking were those most likely to have a fairly high level of education. They were able to accept the probable cause and effect relationship on a logical basis and to abstain. On the other hand, when a analysis was made among smokers, it was found that there were those with a high level of education who rejected the suggested correlation between smoking and lung involvement. The interpretation which appears reasonable insofar as the smokers are concerned is that they were exposed to a mixed biological and emotional need associated with the immediate gratification of cigarette use. This gratification was so appealing that through a system of rationalization they were able to reject the warning.

Application of Principles

Can we apply the principles I have outlined in alcohol and alcoholism education?

Research has established that the action of alcohol in the body is not the same as that of the opiates. There is not a straight line progression—a direct correlation between drinking and alcoholism. That all alcoholics drink is obvious. That all consumers of alcoholic beverages experience the same risk of becoming alcoholics is disproved by the experience of those societies, particularly in southern Europe, in which the use of an alcohol beverage as part of the diet has persisted for years with an extremely low rate of alcoholism. Social drinking has become a widely accepted aspect of our culture. Yet knowledge of the action of alcohol in the body and the dynamics of alcoholism have reached a relatively small proportion of our people. What are the needs in these groups? Can we use the same approach among different groups or must our techniques be tailored according to the needs that are apparent?

It is my belief that we will make limited progress toward a constructive community approach to problems of alcohol until we develop an appreciation of the drinking culture of our society. This means that we must appeal directly to the large body of social drinkers who experience no adverse effects from their use of alcohol and who are unlikely to develop problems. Traditionally the middle class was the backbone of the movement toward prohibition, the movement which the Anti-Saloon League characterized "The Church in Action Against the Saloon." As acceptance of the drinking culture has cut across middle-class lines, there is no doubt that conflict has emerged regarding such acceptance. First of all there must be rejection of the possibility of becoming an alcoholic as a result of drinking, a rejection that identifies alcoholism with some major defect in character and in personality. Just as the cigarette smoker can say, "It cannot happen to me!" so the social drinker, frequently in all sincerity, can say "This is no concern of mine." Yet the average social drinker has little or no understanding of the action in the body and is unable to interpret intelligently to young people, who identify with him, the risks involved in drinking. There are risks involved. There is a risk in drinking and driving. There is a risk of developing a psychological dependence which may have some effect on health if alcohol calories are substituted over long periods of time for calories derived from regular intake of ordinary nu-

trients. There are risks involved for young people, young people for whom emotional and physical maturation and balance have not been achieved and who frequently are likely to respond in a more bizarre fashion to small amounts of alcohol than are adults. How do we reach both the accustomed and the beginning drinker? How do we first of all get their attention to the point where they are willing to listen instead of rejecting us as being concerned only with the skid-row deviant or the psychopathic drinker? And having challenged and gained his attention, what do we say?

During the past few years I have participated in a number of conferences aimed specifically at educators. I am always impressed by the sincerity, by the obvious sense of responsibility of teachers to do more than they have been doing. I am also somewhat appalled at the complete lack of perception which they present about the characteristics of the problem of alcohol education in the classroom and the possibilities of incorporating it in an already crowded curriculum. Can instruction at the secondary school level have any effect on young people? Are they so completely identified with family attitudes, peer group pressures, with the culture of the community that the school has nothing to offer? From the point of view of certain individuals, I would think that perhaps this may be a possibility. However, if you consider a cross-section of the young people coming from the community and taking seats in a classroom, you will find a wide variation in understanding, basic knowledge and perceptions of the function of alcohol in our society. The school has a role to play, a role in this field comparable to that it has played in dealing with other controversial issues. Here for perhaps the first time, young people have a chance to consider different points of view, to perceive the logic as well as the rationalizations that exist in the positions assumed by different groups in our culture and perhaps to arrive at a decision based on knowledge and understanding rather than impulse. To achieve this, however, it is obvious that one of our targets must be pre-service training of teachers and inservice training to the extent that this is possible in our present-day school system.

In reality we have two jobs to do. The first is to reach the key people in the particular target groups that we decide on. This may not be extremely difficult. But the effectiveness of this will depend upon the extent to which our key people can interpret and influence other members of the group. Who are key people? As I have mentioned, it is rather futile to encourage a teacher to become active in the field if her supervisor or administrator has not been persuaded. Similarly, to sell the program that we have to key people in welfare, in corrections, among the clergy and other groups, unless some provision is made for follow-up and extension of the materials, we will fall short of our goal. I am thoroughly convinced that the need to do more exists in the minds of hundreds of thousands of people who have heard about the problem of alcoholism—often through Alcoholics Anonymous. They feel the need to act but fail to perceive the possibility of action and productive results because no systematic coordinated plan for community response — consistent with community norms—has been formulated. The development and implementation of such a program should be a primary aim of an education program.

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leaving, contact was made with a social worker from the Alcoholism and Drug Addiction Research Foundation for further advice on ways of handling this situation. It was suggested that Mrs. A. could perhaps benefit from a referral to Alcoholics Anonymous.

That afternoon when the nurse returned, it was evident that Donald had been busy. The apartment was much tidier, the dishes washed, and he proudly described how he had withstood his mother's entreaties for more alcohol. Donald was commended for his efforts but he needed prodding again before he called his school. Mrs. A. was still very nauseated but more composed. The work of A.A. was described and she indicated considerable interest in seeking their help. She was urged to give them a call, and was reassured that the nurse would return the following day.

Second Day: Because Mrs. A. was in the throes of remorse and guilt, and Donald had returned to school, the nurse decided to remain in the home for the day. There was a gradual return to the nurse-patient relationship as Mrs. A. regained the ability to perform essential tasks and make decisions for herself. She had called A.A. and obtained an appointment for that afternoon. Accompanied by the nurse, Mrs. A., still weak, nauseated, pale and shaky, was able to verbalize some of her problems in response to the understanding and kindly enquiry of the A.A. member. Arrangements were made for an A.A. member to contact Mrs. A. that evening.

Third Day: Provision for emotional support during the weekend became a source of concern. With Mrs. A.'s consent, her girl friend was called and arrangements made for her to visit Mrs. A. In addition, the A.A. member who had contacted her planned to visit. Home visits the following week were planned for every second day. The next month, visits were made each week with the interval between visits gradually extended to once per month.

Mrs. A. regained her health, quit her job and applied for Mother's Allowance. She attended the A.A. meetings regularly, although at first she was unable to see any resemblance between hers and the problems described by other members. She sought counseling for Donald through Child Adjustment Services, Board of Education, and Donald was subsequently referred to Big Brothers' Association. During the first few weeks following Mrs. A.'s initial involvement with A.A., the nurse, private doctor, and Mrs. A.'s friend worked together to provide as much emotional support as possible.

Attempts to help have been built on the existing positive strengths of Mrs. A. and her family (i.e. Mrs. A.'s intelligence, motivation, dependency needs, ability to make friends and her willingness to cooperate). Mrs. A. has frequently become discouraged but has not returned to drinking as an escape. As she became steadily more interested in and perhaps dependent upon A.A., Mrs. A. participated more actively in the meetings. With the development of self-confidence Mrs. A. began giving firmer and more consistent care to the children. However, she is very energetic and needs frequent reminders that when overtired physically, and when diet is unbalanced, she is susceptible to colds and feelings of depression. For Mrs. T., home visits will continue, but as the need decreases the visits will become less frequent.

There are still problems in the relationship between Mrs. A. and Donald. Although successful in his examinations, Donald did not return to school this fall, choosing instead to accept employment at $60 per week in a "dead end" job. Mrs. A. has become increasingly dependent upon him both financially and emotionally. Their quarrels over lack of money subsided for a time after Donald obtained employment, but tension in the home is again high because Donald is spending a great deal of time and money on his first girl friend. The nurse has again suggested that Mrs. A. utilize the counseling services of the Family Service Agency, but to date no appointment has been made.

Admittedly, perhaps Donald was reached too late and with too little assistance, and one wonders how this could have been prevented. His problems escaped an early detection within the school system, partly because he changed schools frequently and partly because of his own withdrawn and shy behavior. At present, Donald's return to the school system is unlikely because of Mrs. A.'s financial dependence upon him. The occasional late afternoon home visit is planned to maintain contact with Donald. As yet little Dianne appears to be a relatively well-adjusted outgoing, boisterous, husky, cheerful child. The public health nurse at Dianne's school has been notified of the problem in the home and is on alert to step in and offer assistance if necessary.

Hope remains that Mrs. A. will continue to gain new insight and accept further counseling and hopefully the outcome will be the development of a much healthier mental health pattern than that which has existed in this family for three generations.

LATEST ON OVER-DRINKING

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try. And, with 5 million alcoholics, you can say that at least 20 million more people are directly affected— the alcoholic himself and his family. This is a tremendous percentage of our population.

As far as the economic problem of alcoholism is concerned, it costs this country an estimated 2 billion dollars a year. Time lost from work through alcoholism is estimated in the hundreds of millions of dollars. The bill for accidents as a result of alcoholism is 125 million dollars. And please bear in mind that, in 1963, over 40,000 people were killed on the highways of our country by automobile accidents, in most of which alcohol was involved.

From 20 to 30 million dollars is spent by public agencies helping the families of alcoholics, and a like amount by private agencies.

Q Does this mean that the U. S. is the most alcoholic nation in the world?

A No. The prevalence of alcoholism in the various countries varies, of course.

The most alcoholic country in the world is France, with 10 per cent of its adult population involved.

The United States shares with South Africa, Chile and Australia the dubious distinction of being second, with 6 per cent of its adult population involved.

Then come the Scandinavian countries, and England, Germany, and so on, with a lesser percentage.

But the United States is second greatest.

Q Why do you think there is so much alcoholism in this country?

A If I were to put my finger on the two greatest contributing factors to the prevalence of alcoholism in this country, the first would be the acceptance of drunken behavior in our society, the tolerance of it. Increasingly, it seems to me, people are accepting drunkenness without being shocked.

The second factor is the social pressures for drinking. Everywhere you go, you are offered liquor. Even during business hours—at luncheons, meetings, conventions. (To Be Continued)

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ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Director; P. O. Box 2371; 915 Dickinson Ave.; Phone: 758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 763-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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